Senate

General Assembly

File No. 209

January Session, 2005

Substitute Senate Bill No. 131

Senate, April 7, 2005

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) All civil actions brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, shall be referred to mandatory mediation pursuant to this section, unless the parties have agreed to refer the civil action to an alternative dispute resolution program. For the purposes of this section, "health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes.

(b) The purpose of such mandatory mediation shall be to (1) review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there

are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant, (2) attempt to achieve a prompt settlement or resolution of the case, and (3) expedite the litigation of the case.

(c) Upon the filing of the answer in such action by the defendant, the clerk of the court for the judicial district in which the case is pending shall refer the case to a judge of the superior court for mediation. The mediation shall commence as soon as practicable, but not later than thirty days after the filing of the answer. The mediation shall not stay or delay the prosecution of the case, nor delay discovery in or the trial of the case.

(d) At the mediation, the court shall review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant. If the court determines that the certificate of good faith is inadequate to permit such a determination, it may order the party submitting the certificate to file, within thirty days, a supplemental certificate setting forth the grounds for the opinion that there has been negligence in the care or treatment of the claimant.

(e) If the court determines that the certificate of good faith or any supplemental certificate is inadequate to support a determination that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant, it shall order the party asserting such a claim to post a cash or surety bond in the amount of five thousand dollars as a condition of continuing the prosecution of the case, which bond shall be used to pay the taxable costs of the other party, as permitted by the general statutes, in the event of the unsuccessful prosecution of the case.

(f) All parties to the case, together with a representative of each insurer that may be liable to pay all or part of any verdict or settlement in the case, shall attend the mediation in person, unless attendance by means of telephone is permitted upon written agreement of all parties

or written order of the court.

(g) If the mediation does not settle or conclude the case, the court shall enter such orders as are necessary to narrow the issues, expedite discovery and assist the parties in preparing the case for trial.

Sec. 2. Section 52-190a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to actions filed on or after said date*):

(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint, **[**or**]** initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. **[**For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,**]** To show the existence of such good faith, the claimant or such claimant's attorney, and any apportionment complainant or such apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity

of the certificate. The claimant or such claimant's attorney, and any apportionment complainant or such apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. The similar health care provider who provides such written opinion shall not, without a showing of malice, be personally liable for any damages to the defendant health care provider by reason of having provided such written opinion. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney or apportionment complainant's attorney submitted the certificate.

(b) If a claimant in a civil action asserts a claim against an apportionment defendant pursuant to subsection (d) of section 52-102b, the requirement under subsection (a) of this section that the attorney or party filing the action make a reasonable inquiry and submit a certificate of good faith shall be satisfied by the submission of a certificate of good faith by the apportionment complainant pursuant to subsection (a) of this section.

[(b)**]** (c) Upon petition to the clerk of the court where the action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

Sec. 3. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Upon the filing of any civil action regarding a medical malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383, the plaintiff or the plaintiff's attorney shall mail a copy of the complaint to the Department of Public Health and the Insurance Department. Receipt or review of a copy of a complaint submitted pursuant to this subsection shall not be considered an investigation of such individual licensee by the Department of Public Health or any examining board.

(b) Upon entry of any medical malpractice award by a court or upon the parties entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall **[**notify**]** provide to the Department of Public Health and the Insurance Department notice of the terms of the award or settlement and **[**shall provide to the department**]** a copy of the award or settlement and the underlying complaint and answer, if any. Such notice and copies provided to the Insurance Department shall not identify the parties to the claim. The Department of Public Health shall send the information received from such entity or party to the state board of examiners having cognizance over any individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim. The **[**department**]** Department of Public Health shall review all medical malpractice complaints, awards and **[**all**]** settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. On and after October 1, 2005, such review shall be conducted in accordance with the guidelines adopted by the Department of Public Health, in accordance with section 20-13b, as amended by this act, to determine the basis for such further investigation or disciplinary action. Any document received pursuant to this section shall not be considered a petition and shall not be subject to **[**the provisions of**]** disclosure under section 1-210 unless the **[**department**]** Department of

Public Health determines, following completion of its review, that further investigation or disciplinary action is warranted. As used in this subsection, "terms of the award or settlement" means the rights and obligations of the parties to a medical malpractice claim, as determined by a court or by agreement of the parties, and includes, but is not limited to, (1) for any individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim, the type of healing art or other health care practice, and the specialty, if any, in which such individual engages, (2) the amount of the award or settlement, specifying the portion of the award or settlement attributable to economic damages, the portion of the award or settlement attributable, if determined by the parties, to noneconomic damages, and, if an award was entered, the portion of the award, if any, attributable to interest awarded pursuant to section 52-192a, as amended by this act, and (3) if there are multiple defendants, the allocation for payment of the award or settlement between or among such defendants.

(c) No release of liability executed by a party to which payment is to be made under a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 shall be effective until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that such attorney has provided the information required under subsection (b) of this section to the Department of Public Health and the Insurance Department.

(d) The Commissioner of Public Health and the Insurance Commissioner shall each develop a system within the commissioner's respective agency for collecting, storing, utilizing, interpreting, reporting and providing public access to the information received under subsections (a) and (b) of this section. Each commissioner shall report the details of such system with respect to the commissioner's agency to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance

on or before October 1, 2005, in accordance with section 11-4a.

Sec. 4. Section 20-13b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health, with advice and assistance from the board, may establish such regulations in accordance with chapter 54 as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1, 2005, such regulations shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) guidelines to provide a basis for prioritizing the order in which complaints will be investigated; (3) a system for conducting investigations to ensure prompt action when it appears necessary; (4) guidelines to determine when an investigation should be broadened beyond the scope of the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations and conducting additional interviews of patients; and (5) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the scope of the initial complaint.

Sec. 5. Section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be within the Department of Public Health a Connecticut Medical Examining Board. Said board shall consist of fifteen members appointed by the Governor, subject to the provisions of section 4-9a, in the manner prescribed for department heads in section 4-7, as follows: Five physicians practicing in the state; one physician who shall be a full-time member of the faculty of The University of Connecticut School of Medicine; one physician who shall be a full-time chief of staff in a general-care hospital in the state; one physician who shall be registered as a supervising physician for one or more physician assistants; one physician who shall be a graduate of a

medical education program accredited by the American Osteopathic Association; one physician assistant licensed pursuant to section 20-12b and practicing in this state; and five public members. No professional member of said board shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the board or have been such an officer during the year immediately preceding appointment or serve for more than two consecutive terms. Professional members shall be practitioners in good professional standing and residents of this state.

(b) All vacancies shall be filled by the Governor in the manner prescribed for department heads in section 4-7. Successors and appointments to fill a vacancy shall fulfill the same qualifications as the member succeeded or replaced. In addition to the requirements in sections 4-9a and 19a-8, no person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed as a public member.

(c) The Commissioner of Public Health shall establish a list of eighteen persons who may serve as members of medical hearing panels established pursuant to **[**subsection (g) of**]** this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of eighteen members appointed by the commissioner, eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have

been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and appointments to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, one of whom shall be a similar health care provider, as defined in section 52-184c, to the person who is the subject of the complaint, and two of whom shall be public members. At least one of the three members shall be a member of the Connecticut Medical Examining Board. The public members may be a member of the board or a member from the list established pursuant to this subsection.

(d) The office of the board shall be in Hartford, in facilities to be provided by the department.

(e) The board shall adopt and may amend a seal.

(f) The Governor shall appoint a chairperson from among the board members. Said board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the

board against such member. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

(g) (1) Not later than July 1, 2005, the board, with the assistance of the department, shall adopt regulations, in accordance with chapter 54, to establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (A) Identification of each type of violation; (B) a range of penalties for each type of violation; (C) additional optional conditions that may be imposed by the board for each violation; (D) identification of factors the board shall consider in determining what penalty should apply; (E) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (F) a provision that when a deviation from the guidelines occurs, the reason for the deviation shall be identified and included as part of the record.

(2) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel **[**within**]** not later than sixty days **[**of**]** after the receipt of charges. **[**This**]** The time period may be extended for good cause by the board in a duly recorded vote. **[**The panel shall consist of three members, at least one of whom shall be a member of the board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.**]** The panel shall conduct a hearing in accordance with the provisions of chapter 54, and the regulations **[**established**]** adopted by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board **[**within**]** not later than one hundred twenty days **[**of**]** after the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote. If the panel does not conduct a hearing within sixty days of the date of referral of the statement of charges by the

board, the commissioner shall conduct a hearing in accordance with chapter 54 and the regulations adopted by the commissioner concerning contested cases. The commissioner shall file a proposed final decision with the board not later than sixty days after such hearing, except that the time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

(h) The board shall review the panel's proposed final decision in accordance with the provisions of section 4-179, and adopt, modify or remand said decision for further review or for the taking of additional evidence. The board shall act on the proposed final decision **[**within**]** not later than ninety days **[**of**]** after the filing of said decision by the panel. **[**This**]** The time period may be extended by the board for good cause in a duly recorded vote.

(i) Except in a case in which a license has been summarily suspended, pursuant to subsection (c) of section 19a-17 or subsection (c) of section 4-182, all three panel members shall be present to hear any evidence and vote on a proposed final decision. The chairperson of the Medical Examining Board may exempt a member from a meeting of the panel if the chairperson finds that good cause exists for such an exemption. Such an exemption may be granted orally but shall be reduced to writing and included as part of the record of the panel within two business days of the granting of the exemption or the opening of the record and shall state the reason for the exemption. Such exemption shall be granted to a member no more than once during any contested case and shall not be granted for a meeting at which the panel is acting on a proposed final decision on a statement of charges. The board may appoint a member to the panel to replace any member who resigns or otherwise fails to continue to serve on the panel. Such replacement member shall review the record prior to the next hearing.

(j) A determination of good cause shall not be reviewable and shall not constitute a basis for appeal of the decision of the board pursuant

to section 4-183.

Sec. 6. Section 20-13i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The department shall file with the Governor and the joint standing committee **[**on public health**]** of the General Assembly having cognizance of matters relating to public health on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the board conducted pursuant to sections 20-13d and 20-13e, as amended by this act. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of petitions not investigated, and the reasons why; the number of hearings held on such petitions; **[**and,**]** the outcome of such hearings; the timeliness of action taken on any petition considered to be a priority; without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition and the actions taken with regard to each such petition by the department and the board; the number of notifications received pursuant to section 19a-17a, as amended by this act; the number of such notifications with no further action taken, and the reasons why; and the outcomes for notifications where further action is taken.

Sec. 7. (NEW) (*Effective from passage*) (a) The Department of Public Health shall develop protocols for accurate identification procedures that shall be used by hospitals and outpatient surgical facilities prior to surgery. Such protocols shall include, but need not be limited to, (1) procedures to be followed to identify the (A) patient, (B) surgical procedure to be performed, and (C) body part on which the surgical procedure is to be performed, and (2) alternative identification procedures in urgent or emergency circumstances or where the patient is nonspeaking, comatose or incompetent or is a child. After October 1, 2005, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed.

(b) Not later than October 1, 2005, the department shall report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health describing the protocols developed pursuant to subsection (a) of this section.

Sec. 8. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, not later than thirty days before trial, file with the clerk of the court a written "offer of judgment" signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action and to stipulate to a judgment for a sum certain. The plaintiff shall give notice of the offer of settlement to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within sixty days after being notified of the filing of the "offer of judgment" or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown not later than the expiration of such sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written "acceptance of offer of judgment" agreeing to a stipulation for judgment as contained in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter judgment immediately on the stipulation. If the "offer of judgment" is not accepted within **[**sixty days**]** the sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the "offer of judgment" shall be considered rejected and not subject to acceptance unless refiled. Any such "offer of judgment" and any "acceptance of offer of judgment" shall be included by the clerk in the record of the case.

(b) After trial the court shall examine the record to determine

whether the plaintiff made an "offer of judgment" which the defendant failed to accept. [If] Except with respect to a civil action described in subsection (c) of this section, if the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's "offer of judgment", the court shall add to the amount so recovered twelve per cent annual interest on said amount. [, computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the]

(c) With respect to any civil action brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, and where the cause of action accrued on or after the effective date of this section, if the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered eight per cent annual interest on said amount, except that if the plaintiff has recovered an amount that is more than twice the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered (1) eight per cent annual interest on the portion of the amount recovered that is equal to or less than twice the sum certain stated in such offer of judgment, and (2) four per cent annual interest on the portion of the amount recovered that is more than twice the sum certain stated in such offer. For the purposes of this subsection, "health care provider" means a provider, as defined in subsection (b) of section 20-7b, or an institution, as defined in section 19a-490.

(d) The interest shall be computed from the date the complaint in the civil action was filed with the court if the "offer of judgment" was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the "offer of judgment" was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars,

and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 9. Section 52-194 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

In any action, the plaintiff may, within **[**ten**]** sixty days after being notified by the defendant of the filing of an offer of judgment, or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown not later than the expiration of such sixty-day period or any extension thereof, file with the clerk of the court a written acceptance of the offer signed by **[**himself or his**]** the plaintiff or the plaintiff's attorney. Upon the filing of the written acceptance, the court shall render judgment against the defendant as upon default for the sum so named and for the costs accrued at the time of the defendant's giving the plaintiff notice of the offer. No trial may be postponed because the period within which the plaintiff may accept the offer has not expired, except at the discretion of the court.

Sec. 10. Subsection (a) of section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14 to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (e) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, at the conclusion of such eighteen-month period. Any such investigation shall be confidential

and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with subsection (b) of this section and the physician agrees to participate in such program in accordance with terms agreed upon by the department and the physician. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause, the petition and the entire record of such investigation shall remain confidential unless the physician requests that such petition and record be open.

(2) If the department makes a finding of no probable cause, it shall notify the person who filed the petition or such person's personal representative and the physician of such finding and the reasons for such finding.

Sec. 11. Subsection (b) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182*l*, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address, the name of the insurance company providing such person's professional liability insurance and the policy number of such insurance, such person's area of specialization, whether such person is actively involved in patient care, any disciplinary action against such person, or malpractice payments made on behalf of such person in any other state or jurisdiction, and such

other information as the department requests. The department may compare information submitted pursuant to this subsection to information contained in the National Practitioner Data Base. Persons may fulfill their obligation to report the information required by this subsection by submitting such information as part of their physician profile, in accordance with section 20-13j, as amended by this act. The department shall revise any forms utilized pursuant to section 20-13j, as amended by this act, to incorporate any additional information required pursuant to this subsection.

Sec. 12. (NEW) (*Effective from passage*) On or before January 1, 2006, and annually thereafter, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, the number of physicians by specialty who are actively providing patient care.

Sec. 13. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to professional liability insurance described in subsection (b) of this section and workers' compensation and employers' liability insurance, on or before the effective date **[**thereof, every**]** of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, **[**every**]** each manual of classifications, rules and rates, and **[**every**]** each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing as described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, as amended by this act, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) (A) Each filing as described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants shall be subject to prior rate approval in accordance with this section. On and after the effective date of this section, each insurer or rating organization seeking to change its rates for such insurance shall (i) file a request for such change with the Insurance Commissioner, and (ii) send written notice of any request for an increase in rates to insureds who would be subject to the increase. Such request shall be filed and such notice, if applicable, shall be sent at least sixty days prior to the proposed effective date of the change. The notice to insureds of a request for an increase in rates shall indicate that the insured may

request a public hearing by submitting a written request to the Insurance Commissioner not later than fifteen days after the date of the notice. Any request for an increase in rates under this subdivision shall be filed after notice is sent to insureds and shall indicate the date such notice was sent.

(B) The insurer or rating organization shall demonstrate in the filing, to the satisfaction of the commissioner, that (i) (I) the insurer or rating organization offers a premium reduction or a separate reduced rating classification for insureds who submit proof to the insurer that the insured and its personnel will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment, and (II) the premium or rate reduction reflects the reduction in risk related to the use of such system, or (ii) if the insurer or rating organization does not offer such premium or rate reduction, that there is no measurable reduction in risk related to the use of such system.

(C) The Insurance Commissioner shall review the filing and, with respect to a request for an increase in rates, shall (i) not approve, modify or deny the request until at least fifteen days after the date of notice as indicated in the filing, and (ii) hold a public hearing, if requested, on such increase prior to approving, modifying or denying the request. The Insurance Commissioner shall approve, modify or deny the filing not later than forty-five days after its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, as amended by this act, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that

any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 14. Section 38a-665 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The following standards, methods and criteria shall apply to the making and use of rates pertaining to commercial risk insurance:

(a) Rates shall not be excessive or inadequate, as **[**herein**]** defined in this section, nor shall **[**they**]** rates be unfairly discriminatory. No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided, or (2) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held inadequate unless (A) it is unreasonably low for the insurance provided, and (B) continued use **[**of it**]** would endanger solvency of the insurer, or unless (C) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer **[**using same has, or, if continued,**]** has, or if continued will have, the effect of destroying competition or creating a monopoly.

(b) (1) Consideration shall be given, to the extent possible, to past and prospective loss experience within and outside this state, to conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country-wide and those specially applicable to this state, to investment income earned or realized by insurers both from their unearned premium and loss reserve funds, and to all other factors, including judgment factors, deemed relevant within and outside this state and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available.

Consideration may be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(2) With respect to rates for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants, consideration shall be given in the making and use of such rates to relevant factors that may reduce such rates, including, but not limited to: (A) Amendments to the offer of judgment provisions in section 52-192a, as amended by this act, and section 52-194, as amended by this act, (B) the other provisions of this act, and (C) any reduction in risk from the use of electronic health record systems to establish and maintain patient records and verify patient treatment.

(c) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) Risks may be grouped by classifications for the establishment of rates and minimum premiums, provided no surcharge on any motor vehicle liability or physical damage insurance premium may be assigned for (1) any accident involving only property damage of one thousand dollars or less, **[**or**]** (2) the first accident involving only property damage of more than one thousand dollars which would otherwise result in a surcharge to the policy of the insured, within the experience period set forth in the insurer's safe driver classification plan, **[**or**]** (3) any violation of section 14-219, unless such violation results in the suspension or revocation of the operator's license under section 14-111b, **[**or**]** (4) less than three violations of section 14-218a within any one-year period, or (5) any accident caused by an operator other than the named insured, a relative residing in the named insured's household, or a person who customarily operates the insured vehicle. Classification rates may be modified to produce rates for

individual risks in accordance with rating plans which provide for recognition of variations in hazards or expense provisions or both. Such rating plans may include application of the judgment of the insurer and may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(e) Each rating plan shall establish appropriate eligibility criteria for determining significant risks which are to qualify under the plan, provided all such plans shall include as an eligible significant risk the state of Connecticut or its instrumentalities. Rating plans which comply with the provisions of this subsection shall be deemed to produce rates **[**which**]** that are not unfairly discriminatory.

(f) Notwithstanding the provisions of subsections (a) to (e), inclusive, of this section, no rate shall include **[**any**]** an adjustment designed to recover underwriting or operating losses incurred out-of-state.

(g) The commissioner may adopt regulations in accordance with the provisions of chapter 54 concerning rating plans to **[**effectuate**]** implement the provisions of this section.

Sec. 15. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to causes of action accruing on or after said date*):

(a) In any claim or civil action to recover damages resulting from personal injury, wrongful death or damage to property occurring on or after October 1, 1987, the attorney and the claimant may provide by contract, which contract shall comply with all applicable provisions of the rules of professional conduct governing attorneys adopted by the judges of the Superior Court, that the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) the settlement amount received pursuant to a settlement agreement.

(b) In any such contingency fee arrangement such fee shall be the

exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) (1) Whenever a claimant in a medical malpractice claim or civil action enters into a contingency fee arrangement with an attorney which provides for a fee that would exceed the percentage limitations set forth in subsection (b) of this section, such fee arrangement shall not be valid unless the claimant's attorney files an application with the court for approval of such fee arrangement and the court, after a hearing, grants such application. The claimant's attorney shall attach to such application a copy of such fee arrangement and the proposed unsigned writ, summons and complaint. Such fee arrangement shall provide that the attorney will advance all costs in connection with the investigation and prosecution or settlement of the medical malpractice claim or civil action and the claimant will not be liable for the reimbursement of the attorney for any such costs if there is no recovery.

(2) At the hearing required under subdivision (1) of this subsection, the court shall address the claimant personally to determine if the claimant understands his or her rights under subsection (b) of this section and has knowingly and voluntarily waived such rights. The court shall grant such application if it finds that the claimant has knowingly and voluntarily waived such rights and that the medical malpractice claim or civil action is so substantially complex, unique or different from other medical malpractice claims or civil actions as to warrant a deviation from such percentage limitations. The claimant's attorney shall have the burden of showing at the hearing that such deviation is warranted. In no event shall the court grant an application

approving a fee arrangement that provides for a fee that exceeds an amount equal to thirty-three and one-third per cent of the damages awarded and received by the claimant or of the settlement amount received by the claimant. If the court denies the application, the court shall advise the claimant of the claimant's right to seek representation by another attorney willing to abide by the percentage limitations set forth in subsection (b) of this section. Only one application may be filed under this subsection with respect to the claimant and the claimant's medical malpractice claim or civil action.

(3) The filing of such application shall toll the applicable statute of limitations until ninety days after the court's decision to grant or deny the application. The decision of the court to grant or deny the application shall not be subject to appeal. The Chief Court Administrator shall assign a judge or judges with experience in personal injury claims or civil actions to hear and determine applications filed under this subsection. A transcript of the hearing shall be prepared, and such transcript shall be sealed and available for the use of the court only.

(d) If the attorney makes disbursements or incurs costs in connection with the investigation and prosecution or settlement of the claim or civil action for which the claimant is liable, in no event shall the claimant be required to pay interest on the amount of such disbursements and costs.

[(c) For**]** (e) (1) Except as provided in subdivision (2) of this subsection, for the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant; **[**, except that in a civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement; **[**, except that in a claim

or civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense.

(2) For the purposes of this section with respect to a medical malpractice claim or civil action in which an application was granted by a court pursuant to subsection (c) of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the civil action, other than ordinary office overhead and expense, for which the claimant is liable; and "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense, for which the claimant is liable.

[(d)**]** (f) For the purposes of this section, "medical malpractice claim or civil action" means a claim or civil action brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, and "health care provider" means a provider, as defined in subsection (b) of section 20-7b, or an institution, as defined in section 19a-490.

Sec. 16. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2006*):

[The Insurance Commissioner may require all insurance companies

writing medical malpractice insurance in this state to submit, in such manner and at such times as he specifies, such information as he deems necessary to establish a data base on medical malpractice, including information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved and any other information relating to risk management.**]**

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a physician, surgeon, hospital, advanced practice registered nurse or physician assistant pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; and

(3) "Insurer" means an insurer that insures a physician, surgeon, hospital, advanced practice registered nurse or physician assistant against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person.

(b) On and after January 1, 2006, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the

insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as from time to time amended, submitted pursuant to this subdivision shall be confidential. The reporting of the information is required by law. If necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, the insured shall arrange with the insurer to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed, and if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed, and if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the

amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to failure to accept an offer of judgment; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to physicians, surgeons, hospitals, advanced practice registered nurses or physician assistants, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for physicians, surgeons, hospitals, advanced practice registered nurses and physician assistants, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each

specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2007, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner.

Sec. 17. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health shall develop and implement a process to ensure a continuing and coordinated focus on patient safety programs within the Department of Public Health. Such process shall encompass activities undertaken by the department to (1) coordinate state initiatives on patient safety, (2) facilitate ongoing collaborations between the public and private sectors, (3) promote patient safety through education of health care providers and patients, (4) assure coordination in collecting, analyzing and responding to adverse events reports submitted to the department pursuant to section 19a-127n of the general statutes, (5) coordinate state and federal patient safety programs, (6) participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors, and (7) promote the recommendations of the Quality of Care Advisory Committee established in section 19a-127*l* of the general statutes.

(b) On or before January 1, 2006, and annually thereafter, the Commissioner of Public Health shall submit a report, in accordance

with the provisions of section 11-4a of the general statutes, to the Governor and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, providing a description of the process developed pursuant to subsection (a) of this section, an analysis of its operation and impact with respect to the activities enumerated in subsection (a) of this section, a description of the activities undertaken by the department's patient safety programs, and recommendations for future action.

Sec. 18. (NEW) (*Effective from passage*) Whenever in a civil action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the jury renders a verdict specifying noneconomic damages, as defined in section 52-572h of the general statutes, in an amount exceeding one million dollars, the court shall review the evidence presented to the jury to determine if the amount of noneconomic damages specified in the verdict is excessive as a matter of law in that it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake or corruption. If the court so concludes, it shall order a remittitur and, upon failure of the party so ordered to remit the amount ordered by the court, it shall set aside the verdict and order a new trial. For the purposes of this section, "health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes.

Sec. 19. Section 38a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Insurance Commissioner is the agent for receipt of service of legal process on the following:

(1) Foreign and alien insurance companies authorized to do business in this state in any proceeding arising from or related to any transaction having a connection with this state.

(2) Fraternal benefit societies authorized to do business in this state.

(3) Insurance-support organizations as defined in section 38a-976, transacting business outside this state which affects a resident of this state.

(4) Risk retention groups, [designating the Insurance Commissioner as agent for receipt of service of process pursuant to section 38a-252] as defined in section 38a-250.

(5) Purchasing groups designating the Insurance Commissioner as agent for receipt of service of process pursuant to section 38a-261.

(6) Eligible surplus lines insurers authorized by the commissioner to accept surplus lines insurance.

(7) Except as provided by section 38a-273, unauthorized insurers or other persons assisting unauthorized insurers who directly or indirectly do any of the acts of insurance business as set forth in subsection (a) of section 38a-271.

(8) The Connecticut Insurance Guaranty Association and the Connecticut Life and Health Insurance Guaranty Association.

(9) Insurance companies designating the Insurance Commissioner as agent for receipt of service of process pursuant to subsection (g) of section 38a-85.

(10) Nonresident insurance producers and nonresident surplus lines brokers licensed by the Insurance Commissioner.

(11) Viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents licensed by the commissioner.

(12) Nonresident reinsurance intermediaries designating the commissioner as agent for receipt of service of process pursuant to section 38a-760b.

(13) Workers' compensation self-insurance groups, as defined in

section 38a-1001.

(14) Persons alleged to have violated any provision of section 38a-130.

(15) Captive insurers, as defined in section 20 of this act.

(b) Each foreign and alien insurer by applying for and receiving a license to do insurance business in this state, each fraternal benefit society by applying for and receiving a certificate to solicit members and do business, each surplus lines insurer declared to be an eligible surplus lines insurer by the commissioner, each insurance-support organization transacting business outside this state which affects a resident of this state, and each unauthorized insurer by doing an act of insurance business prohibited by section 38a-272, is considered to have irrevocably appointed the Insurance Commissioner as **[**his**]** agent for receipt of service of process in accordance with subsection (a) of this section. Such appointment shall continue in force so long as any certificate of membership, policy or liability remains outstanding in this state.

(c) The commissioner is also agent for the executors, administrators or personal representatives, receivers, trustees or other successors in interest of the persons specified under subsection (a) of this section.

(d) Any legal process that is served on the commissioner pursuant to this section shall be of the same legal force and validity as if served on the principal.

(e) The right to effect service of process as provided under this section does not limit the right to serve legal process in any other manner provided by law.

Sec. 20. (NEW) (*Effective July 1, 2005*) Each captive insurer that offers, renews or continues insurance in this state shall provide the information described in subdivisions (1) to (3), inclusive, of subsection (a) of section 38a-253 of the general statutes to the Insurance Commissioner in the same manner required for risk retention groups.

If a captive insurer does not maintain information in the form prescribed in section 38a-253 of the general statutes, the captive insurer may submit the information to the Insurance Commissioner on such form as the commissioner prescribes. As used in this section and section 38a-25 of the general statutes, as amended by this act, "captive insurer" means an insurance company owned by another organization whose primary purpose is to insure risks of a parent organization or affiliated persons, as defined in section 38a-1 of the general statutes, or in the case of groups and associations, an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations and group members and their affiliates.

Sec. 21. Subsection (b) of section 20-13j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(b) The department, after consultation with the Connecticut Medical Examining Board and the Connecticut State Medical Society shall collect the following information to create an individual profile on each physician for dissemination to the public:

(1) The name of the medical school attended by the physician and the date of graduation;

(2) The site, training, discipline and inclusive dates of the physician's postgraduate medical education required pursuant to the applicable licensure section of the general statutes;

(3) The area of the physician's practice specialty;

(4) The address of the physician's primary practice location or primary practice locations, if more than one;

(5) A list of languages, other than English, spoken at the physician's primary practice locations;

(6) An indication of any disciplinary action taken against the physician by the department, **[**or by**]** the state board or any

professional licensing or disciplinary body in another jurisdiction;

(7) Any current certifications issued to the physician by a specialty board of the American Board of Medical Specialties;

(8) The hospitals and nursing homes at which the physician has admitting privileges;

(9) Any appointments of the physician to Connecticut medical school faculties and an indication as to whether the physician has current responsibility for graduate medical education;

(10) A listing of the physician's publications in peer reviewed literature;

(11) A listing of the physician's professional services, activities and awards;

(12) Any hospital disciplinary actions against the physician that resulted, within the past ten years, in the termination or revocation of the physician's hospital privileges for a medical disciplinary cause or reason, or the resignation from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to medical competence in such hospital;

(13) A description of any criminal conviction of the physician for a felony within the last ten years. For the purposes of this subdivision, a physician shall be deemed to be convicted of a felony if the physician pleaded guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere; **[**and**]**

(14) To the extent available, and consistent with the provisions of subsection (c) of this section, all medical malpractice court judgments and all medical malpractice arbitration awards against the physician in which a payment was awarded to a complaining party during the last ten years, and all settlements of medical malpractice claims against the

physician in which a payment was made to a complaining party within the last ten years;

(15) An indication as to whether the physician has current responsibility for providing direct patient care services; and

(16) The name of the physician's professional liability insurance carrier and the policy number.

Sec. 22. Subsection (k) of section 20-13j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(k) A physician shall notify the department of any changes to the information required in **[**subdivisions (3), (4), (5), (7), (8) and (13) of**]** subsection (b) of this section, as amended by this act, not later than sixty days after such change.

Sec. 23. Sections 38a-32 to 38a-36, inclusive, of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage and applicable to actions filed on or after said date*	52-190a
Sec. 3	*from passage*	19a-17a
Sec. 4	*from passage*	20-13b
Sec. 5	*from passage*	20-8a
Sec. 6	*from passage*	20-13i
Sec. 7	*from passage*	New section
Sec. 8	*from passage*	52-192a
Sec. 9	*from passage*	52-194
Sec. 10	*from passage*	20-13e(a)
Sec. 11	*from passage*	19a-88(b)
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	38a-676
Sec. 14	*from passage*	38a-665

Sec. 15	*from passage and applicable to causes of action accruing on or after said date*	52-251c
Sec. 16	*January 1, 2006*	38a-395
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	38a-25
Sec. 20	*July 1, 2005*	New section
Sec. 21	*October 1, 2005*	20-13j(b)
Sec. 22	*October 1, 2005*	20-13j(k)
Sec. 23	*from passage*	38a-32 to 38a-36 repealed

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 06$	FY 07$
Public Health, Dept.	GF - Cost	672,365	660,065
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	149,505	355,760
Insurance Dept.	IF - Cost	173,929	173,929
UConn Health Ctr.	GF - Savings	Potential	Potential

Note: GF=General Fund; IF=Insurance Fund

Municipal Impact: None

Explanation

The bill results in costs to the Department of Public Health and the Department of Insurance and potential savings to the University of Connecticut Health Center. A section-by-section analysis follows.

Section 1 requires parties to a civil action involving medical malpractice to engage in mandatory mediation by a judge of the superior court. Such mediation shall not stay or delay the prosecution of the case, and shall be for the specified purposes of: (1) reviewing certificates of good faith; (2) attempting to achieve prompt settlement or resolution of cases; and (3) expediting litigation of cases. To the extent that this new process speeds disposition of medical malpractice cases, a workload reduction to the Civil Division of the Superior Court would result.

Section 2 requires plaintiffs to submit a certificate of good faith for any apportionment complaint related to medical malpractice. This requirement could reduce the scope of some malpractice cases and thereby promote quicker disposition. There is no related fiscal impact.

Sections 3-5 would result in a significant cost to the Department of Public Health (DPH). The predominant reason for this is a

requirement that the agency review and investigate when warranted all medical malpractice claims filed against a licensed physician, chiropractor, dentist or psychologist. Under current law, the agency reviews about 500 complaints and malpractice payment notices annually. Of these, about fifty percent (or 250) progress to an investigation. Under the bill, an additional 380 – 400 filed claims would require agency review each year, prompting an additional 190 – 200 investigations. The agency's Practitioner Investigations Unit currently has nine investigators.

The department's workload would also be increased to the extent that: (a) filed claims involve cases in which multiple medical practitioners are named, (b) the scope of reviews/investigations is broadened following adoption of regulations, and (c) medical review panels convened by the Connecticut Medical Examining Board (CMEB) ask for reconsideration of findings of no probable cause. (The agency dismisses about 240 cases each year concerning physicians following an investigation.)

Additional work would be associated with developing regulations, and developing systems for public access to information received about medical malpractice claims, awards and settlements and reporting on the same to the Public Health and Insurance Committees by October 1, 2005.

The DPH will incur FY 06 costs of $502,745 to comply with **Sections 3-5**. This reflects the full-year salaries of: one Physician (at $142,000 annually), one Supervising Nurse Consultant (at $75,600 annually), two Nurse Consultants (at $68,640 annually), one Administrative Hearings Officer (at an annual salary of $70,000), one Office Assistant (at an annual salary of $38,100), and one half-time Systems Developer (at $32,165 annually). Also included are one-time equipment costs of $7,600. In FY 07 this cost will decrease to $495,145 as equipment costs will not recur. DPH costs will be supplemented by fringe benefit costs of $112,150 in FY 06 and $266,930 in FY 07. A potential minimal revenue gain would be expected should the enhanced investigation

process lead to the collection of additional financial penalties from health care professionals.

Section 5 requires the Connecticut Medical Examining Board (CMEB), with the assistance of the DPH, to adopt regulations by July 1, 2005, to establish guidelines for use in its disciplinary process. It also establishes a requirement that the CMEB refer all findings of no probable cause to a medical hearing panel within 60 days of receipt from the DPH. The CMEB and medical hearing panels are comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members.

Section 6 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 06 costs of $19,855 to support the salary of one half-time Office Assistant (at an annual salary of $19,055) needed to enter data not presently collected and/or entered into the agency's database, and one-time associated equipment costs of $800. In FY 07 this cost will fall to $19,055 as the equipment costs will not recur. DPH costs will be supplemented by fringe benefit costs of $4,315 in FY 06 and $10,275 in FY 07. Modifications to the agency's computerized complaints database will also be needed. It is expected that the Systems Developer position needed to implement Sections 3-5 and 11-12 would assume these duties.

Section 7 requires the DPH to establish protocols for use by each hospital or outpatient surgical facility for screening patients prior to any surgery and report on the same by October 1, 2005. It is anticipated that the agency can do so without requiring additional resources. To the extent that following these protocols lowers medical malpractice and malpractice insurance costs, the John Dempsey Hospital may realize future savings. The extent of these savings cannot be determined at this time.

Sections 8 & 9 make changes to the offer of judgment provisions in current law. These changes are not expected to substantially alter the

period of time it takes to dispose of civil cases on a system wide basis such that there would be a fiscal impact to the Judicial Department.

Section 10 requires DPH to notify the physician and the person who filed the petition or his legal representative when it makes a find of no probable cause. It is anticipated that the agency will be able to do so within its anticipated budgetary resources.

Sections 11 & 12 require each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization and whether he or she is actively involved in patient care. It also allows DPH to compare this information to that contained in the National Practitioner Data Base. **Section 12** also requires the DPH to report, by January 1, 2006, and annually thereafter, on the number of physicians by specialty who are actively providing patient care.

The DPH will incur FY 06 costs of $73,365 to support the salaries of one Office Assistant (at an annual salary of $38,100), and one half-time Systems Developer (at an annual salary of $32,165) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for equipment ($1,600) and reprinting the physician renewal card ($1,500). In FY 07 this cost will fall to $70,265 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $15,915 in FY 06 and $37,880 in FY 07. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs $4.25.

The DPH will incur FY 05 costs of $70,600 to support the salaries of one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at an annual salary of $31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for

equipment ($3,000) and reprinting the physician renewal card ($1,500). In FY 06 this cost will fall to $66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $6,320 in FY 05 and $14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs $4.25 and no funding has been appropriated to the department for this purpose within sHB 5033.

Section 13 requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. This has no fiscal impact on the Department of Insurance.

Section 14 requires insurers and the Insurance Commissioner to consider relevant factors that may reduce rates when establishing malpractice rates. This does not result in a fiscal impact.

Section 15 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. There is no related fiscal impact.

Section 16 requires the Insurance Commissioner to establish an electronic database composed of closed claim reports. It also requires the commissioner to provide an annual report consisting of trend analysis of closed claim information. Due to the need to collect, input, and process additional information the department would incur costs of $173,929 in FY 06 and FY 07. These costs would consist of $51,200 in other expenses and equipment, $89,920 in salary and fringe benefits for an examiner (annual salary $61,665), and $32,810 in salary and fringe benefits for one-quarter of an actuary.

Section 17 requires the DPH to develop and implement a process that will ensure a continuing and coordinated focus on patient safety programs within the department and submit an annual report, commencing on or before January 1, 2006, to the Public Health Committee. An FY 06 cost of $76,400 will result for the DPH to reflect the salary of one Nurse Consultant (at an annual salary of $75,600) and

one-time equipment costs (of $800). These costs will fall to $75,600 in FY 07 as the equipment costs will not recur. This position will be required to coordinate state initiatives on patient safety, facilitate public/private collaborations, educate health care provides and patients, oversee the handling of adverse events reports, coordinate state and federal patient safety programs, participate in the Patient Safety Improvement Corps and promote the recommendations of the Quality of Care Advisory Committee. DPH costs will be supplemented by fringe benefit costs of $17,125 in FY 06 and $40,755 in FY 07.

Section 18 requires the court to review jury verdicts in medical malpractice cases if the award for non-economic damages is deemed to be potentially excessive. There is no associated fiscal impact

Sections 19 & 20 require that each captive insurer that offers, renews, or continues, insurance in Connecticut to provide certain information to the Insurance Commissioner. The bill also requires the Insurance Commissioner to bill as agent for service process for risk retention groups domiciled outside the United States and for captive insurers. This has no fiscal impact.

Sections 21 and 22 make changes to the information that must be reported by physicians within their physician profiles. It is anticipated that the DPH can accommodate these changes without requiring additional resources.

Section 23 eliminates the voluntary medical malpractice-screening panel. As this conforms statute to current practice, there is no fiscal impact.

OLR Bill Analysis
sSB 131

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM

SUMMARY:
This bill makes numerous changes in the laws dealing with medical malpractice litigation; medical malpractice insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Regarding medical malpractice litigation reform, the bill:

1. establishes a mandatory mediation program (§ 1);

2. requires, as a condition of filing a medical malpractice lawsuit, a signed opinion of a similar health care provider indicating that malpractice has occurred (§ 2);

3. reduces the interest rate the court may award the plaintiff on an offer of judgment (§ 8); and

4. allows attorneys to charge more than the law normally allows only with court approval and prohibits fees greater than one-third of the damages awarded (§ 15).

It also (1) requires the court to review the evidence in medical malpractice cases that award $1 million or more in noneconomic damages to determine if the award is excessive as a matter of law (§ 18); (2) gives plaintiffs 60 days instead of 10 to accept a defendant's offer of judgment and allows courts to give plaintiffs and defendants up to an additional 120 days to accept an offer of judgment (§§ 8 & 9); and (3) eliminates the Medical Malpractice Screening Panel (§ 21).

Regarding insurance regulation and oversight, the bill:

1. requires prior rate approval for medical malpractice insurance rate changes for physicians, hospitals, and certain other health care providers and requires insurers either to offer a discount

for those who use an electronic records system or demonstrate that its use does not reduce the risk (§ 13);

2. requires insurers to consider specified relevant factors that may reduce rates when establishing malpractice insurance rates (§ 14);

3. requires insurers to report to the insurance commissioner on each malpractice claim that they close and requires her to compile and analyze the reported data, and report on it to the Insurance and Real Estate Committee and the public (§ 16); and

4. requires captive insurers to provide certain information to the insurance commissioner (§§ 19 and 20).

Regarding medical provider regulation and oversight, the bill:

1. requires medical malpractice litigants to provide certain information to the Insurance and Public Health (DPH) departments, which make the information available to the public (§§ 3 & 4);

2. requires DPH and the Medical Examining Board to adopt guidelines for investigating complaints against physicians (§§ 3, 4, 5, and 10);

3. requires DPH's annual report to include additional information about medical malpractice cases (§ 6);

4. requires DPH to develop surgury protocols (§ 7);

5. requires doctors annually to provide certain information to DPH (§ 11);

6. requires DPH to report annually the number of doctors, by specialty, actively providing patient care (§ 12);

7. requires the DPH commissioner to develop and implement a process to ensure its focus on patient safety programs (§ 17);

8. requires DPH to collect additional information about physicians for the physician profile including disciplinary actions that

occurred out of state (§ 21); and

9. requires physicians to notify DPH of changes in any information in their profiles instead of just changes in certain information in it (§ 22).

EFFECTIVE DATE: Upon passage, except for the provision dealing with the duty of captive insurers to provide certain information to the insurance commissioner, which takes effect July 1, 2005; the provisions concerning physician's profiles which take effect October 1, 2005; and the provision requiring data on closed cases which takes effect January 1, 2006.

MANDATORY MEDIATION (§ 1)

The bill establishes a mandatory mediation program for all medical malpractice lawsuits filed after the bill becomes law to:

1. review the good faith certificate the complainant filed to determine whether there are grounds for a good faith belief that the defendant was negligent,

2. attempt to achieve a prompt settlement or resolution of the case, and

3. expedite ensuing litigation.

A medical malpractice case must be referred to mandatory mediation unless the parties have agreed to refer the case to an alternative dispute resolution program. The court clerk must refer it to a Superior Court judge for mediation when the defendant files his answer. The mediation must occur as soon as is practicable but no later than 30 days after the answer is filed. The bill specifies that mediation does not stay or delay the lawsuit or delay discovery.

At the mediation, the court must review the good faith certificate to determine if there are grounds for a good faith belief that the defendant was negligent in the claimant's care or treatment. If the court determines that the certificate is inadequate to permit such a determination, it may order the complainant to file a supplemental certificate within 30 days.

If the court determines that the original certificate or supplemental certificate is inadequate, it must order the claimant to post a $5,000 cash or surety bond as a condition of continuing the case. The bond must be used to pay the other party's taxable costs if the case is not successfully prosecuted.

The bill requires all parties to the case, together with a representative of each insurer that may be liable, to attend the mediation in person, unless the parties agree to, or the court orders, a telephone conference.

If the mediation does not settle or conclude the case, the court must enter whatever orders are necessary to narrow the issues, expedite discovery, and help the parties prepare the case for trial.

The mediation requirement applies to all DPH-licensed health care providers (individuals and institutions) including doctors, surgeons, dentists, pharmacists, psychologists, and emergency medical technicians (see BACKGROUND for complete list).

GOOD FAITH CERTIFICATE (§ 2)

The law prohibits filing malpractice lawsuits unless the attorney or claimant has made as reasonable an inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that the claimant received negligent care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that his inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief can be shown if the claimant or his attorney receives a written opinion from a similar health care provider that there appears to be evidence of medical negligence. But it can also be shown in some other way. The bill instead requires a written signed opinion from a similar health care provider in order to show the existence of good faith. The opinion must include the reasons for concluding that medical negligence had occurred.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the health care provider's name and signature removed.

The bill imposes the same good faith certificate requirement on

defendants who file an apportionment complaint against another health care provider as applies to the plaintiff. (An apportionment complaint is a defendant's claim in a medical malpractice lawsuit that another health care provider who the plaintiff did not make a defendant committed malpractice and partially or totally caused the plaintiff's damages. By filing the apportionment complaint, the defendant in essence makes the other health care provider a party to the plaintiff's lawsuit.) Under the bill, if a plaintiff asserts a claim against a party added to the case by an apportionment complaint, he is not required to submit a certificate of good faith regarding that person.

The bill makes the health care provider who provides the opinion immune from liability unless it is shown he acted with malice.

By law, the court may impose sanctions if a certificate was not made in good faith.

NOTICE OF LAWSUITS TO DPH AND INSURANCE DEPARTMENT (§ 3)

The bill requires that, upon filing a medical malpractice case against certain health care providers, the plaintiff or his attorney mail a copy of the complaint to DPH and the Insurance Department. The requirement applies to lawsuits filed against licensed physicians, chiropractors, natureopaths, dentists, podiatrists, optometrists, and psychologists. The receipt or review of a copy of a complaint may not be considered an investigation of the licensee by DPH or any examining board.

By law, anyone who pays damages in such a medical malpractice case must notify DPH of the terms of the award or settlement and provide a copy of it and the underlying complaint and answer, if any. The bill requires that the notification to specify the portion attributable to economic damages and, if determined by the parties, the portion attributable to noneconomic damages. It also requires that (1) if there are multiple defendants, the information include how the award must be allocated and (2) the portion of the award attributable to the offer of judgment law.

The bill requires that (1) the person who pays damages also provide this information to the Insurance Department without identifying the parties to the claim and (2) DPH send this information to the state board of examiners that oversees the health care provider who was a

defendant in the lawsuit.

By law, DPH must review all medical malpractice awards and settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. The bill requires DPH to review all malpractice complaints as well. It requires that, beginning October 1, 2005, DPH conduct its reviews according to guidelines it adopts to determine the basis for further investigation or disciplinary action.

The bill requires the public health and insurance commissioners to develop systems in their respective agencies to collect, store, use, interpret, report, and provide public access to the information. It requires each commissioner to report the details of these systems to the Public Health and Insurance and Real Estate committees by October 1, 2005.

By law and practice, people receiving a settlement in a malpractice claim sign a liability release to the person or entity paying the settlement. The bill makes such releases in connection with settlements with health care providers invalid until the attorney for the entity making payment or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that he has provided the information the bill and law require to DPH and the Insurance Department. The requirement applies to claims against licensed physicians, chiropractors, natureopaths, dentists, podiatrists, optometrists, and psychologists.

DPH INVESTIGATION GUIDELINES CONCERNING COMPLAINTS AGAINST PHYSICIANS (§ 4)

By law, the DPH commissioner, with the Connecticut Medical Examining Board's advice and assistance, may establish regulations to carry out his oversight and regulatory duties. The bill requires the commissioner, by July 1, 2005, to adopt regulations that establish:

1. guidelines for screening complaints that physicians may be unable to practice medicine with reasonable skill and safety to determine which complaints it will investigate and in what order;

2. a system for conducting investigations to ensure prompt action

when it appears necessary;

3. guidelines to determine when an investigation should be broadened to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers; and

4. guidelines to protect and ensure the confidentiality of patient and provider identities when an investigation is broadened.

DISCIPLINARY GUIDELINES AND HEARING PROCEEDINGS AGAINST DOCTORS (§ 5)

The 15-member Connecticut Medical Examining Board may restrict, suspend, or revoke a physician's license or limit his right to practice for certain misconduct. The bill requires that, by July 1, 2005, the board, with DPH's assistance, adopt regulatory guidelines for use in the disciplinary process. The guidelines must include (1) identification of each type of violation; (2) a range of penalties for each type of violation; (3) additional conditions that the board may impose; (4) identification of factors the board must consider to determine if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that the board may consider in deviating from the guidelines; and (6) a requirement for specifying the reason for any deviation from the guidelines.

By law, the board must refer all statements of charges DPH files with it to a hearing panel within 60 days of receiving them. Under current law, the three-member medical hearing panel had to include a board member and a public member. The bill requires instead that one member must be a similar health care provider to the person who is the subject of the complaint and two must be public members. At least one of the three members must be a Medical Examining Board Member. The public members may be board members or selected from the list of 18 people established by the DPH commissioner.

By law, the panel must conduct a hearing on contested cases. It must file a proposed final decision with the board within 120 days after it receives notice of the hearing. The board may, for good cause, vote to extend this deadline. The bill requires the DPH commissioner to

conduct the hearing if the panel has not done so within 60 days of the date the board refers the statement of charges. The hearing must be conducted according to DPH regulations governing contested cases. The bill requires the commissioner to file a proposed final decision with the board within 60 days after the hearing. The board, for good cause, may vote to extend the filing deadlines. The bill does not specify whether the board must accept the commissioner's decision.

DPH ANNUAL REPORTS OF DISCIPLINARY ACTIVITIES (§ 6)

By law, DPH must file with the governor and Public Health Committee an annual report of its disciplinary activities. The bill requires that the report specify (1) the number of petitions and lawsuit notices not investigated and the reasons why, (2) the outcome of the hearings held on petitions and notices DPH investigated, and (3) the timeliness of action taken on petitions and notices considered to be a priority.

PRE-SURGICAL PROTOCOLS (§ 7)

The bill requires DPH to develop protocols for accurate identification procedures that hospitals and outpatient surgical facilities must use before surgery. The protocols must include (1) procedures to identify the patient, the surgical procedure to be performed, and the body part on which it is to be performed and (2) alternative identification procedures in urgent or emergency circumstances or where the patient cannot speak or is comatose, incompetent, or a child. After October 1, 2005, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed. DPH must report to the Public Health Committee by October 1, 2005 on the protocols it develops.

OFFER OF JUDGMENT BY PLAINTIFFS (§ 8)

By law, the plaintiff in a contract case or a case seeking money damages may, up to 30 days before trial, file with the court clerk a written "offer of judgment" to settle the claim for a specific amount. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment that the defendant failed to accept. If it determines that the plaintiff recovered an amount equal to or greater than the sum stated in his offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file an acceptance of the offer with the court clerk. The bill allows the court to grant the defendant one or more extensions of up to 120 additional days to file an acceptance.

The bill changes the interest rate the court may award with respect to an offer of judgment for medical malpractice cases that accrue after its effective date. It does so by reducing (1) from 12% to 8% the interest the court must add to the portion of the award up to twice the amount stated in the offer of judgment and (2) from 12% to 4% the interest the court must add to the portion of the award that exceeds twice the amount stated in the offer.

This change applies to medical malpractice lawsuits against health care providers and institutions (See BACKGROUND).

OFFER OF JUDGMENT BY DEFENDANT (§ 9)

By law, in any contract case or case seeking money damages, the defendant may, up to 30 days before trial, file a written offer of judgment with the court clerk to settle the case for a specific amount. The bill gives the plaintiff 60 instead of 10 days after being notified of the defendant's offer to accept it. It also authorizes the court to grant the plaintiff one or more extensions up to 120 additional days for good cause. By law, if the plaintiff recovers less than the offer of judgment, he must pay the defendant's costs accruing after he received his offer, including reasonable attorney's fees up to $300.

NOTICE TO PETITIONER AND PHYSICIAN OF NO PROBABLE CAUSE FINDING (§ 10)

The law requires DPH to investigate each complaint petition filed with it to determine if probable cause exists to institute proceedings against the physician. The bill requires DPH to notify the physician and the person who filed the petition or his legal representative when it makes a finding of no probable cause. It must include the reason for such finding.

DPH DATA REGARDING PRACTITIONERS (§ 11 & 12)

By law, anyone licensed to practice medicine, podiatry, chiropractic, or naturopathy must register annually with DPH and provide his name, residence, business address, and other information DPH requests. The

bill requires the licensee also to provide the name of his malpractice insurer and the policy number, his area of specialization, whether he is actively involved in patient care, and any disciplinary action against him or malpractice payments made on his behalf in any other state or jurisdiction. The bill authorizes DPH to compare this information submitted to information contained in the National Practitioner Data Base.

The bill allows doctors to fulfill their obligation to report this information by submitting it as part of their statutorily required physician profile. It requires DPH to revise any forms used for physician profiles to incorporate the additional required information.

NUMBER OF PHYSICIANS (§ 12)

The bill requires DPH, beginning January 1, 2006, to report annually to the General Assembly the number of physicians, by specialty, actively providing patient care in Connecticut.

PRIOR MALPRACTICE INSURANCE RATE APPROVAL (§ 13)

The bill subjects malpractice insurance rates for physicians, hospitals, advanced practice registered nurses, and physician assistants to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to change its rates must file a request with the Insurance Department and send written notice to all affected insureds at least 60 days before the change's effective date.

The insurer or rating organization must demonstrate to the commissioner's satisfaction that (1) it offers a premium reduction or a separate reduced rating classification for insureds who submit proof that they and their personnel will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment and (2) the premium or rate reduction reflects the reduction in risk related to using such a system.

As an alternative, if the insurer or rating organization does not offer such a premium or rate reduction, it must demonstrate to the commissioner's satisfaction that there is no measurable reduction in risk related to using such a system.

Any request for a rate increase must be filed after notice is sent to insureds and must indicate the date the notice was sent. The notice must indicate that the insured may request a public hearing by submitting a written request to the insurance commissioner within 15 days after the notice date.

The bill prohibits the insurance commissioner from approving, modifying, or denying a rate increase until at least 15 days after the date of notice as indicated in the filing. It requires the commissioner to hold a public hearing, if requested, on an increase before acting. The commissioner must approve, modify, or deny the filing within 45 days after its receipt. Her decision may be appealed to Superior Court.

MALPRACTICE RATES (§ 14)

The bill requires insurers and the commissioner to consider relevant factors that may reduce rates when establishing malpractice rates for physicians and surgeons, hospitals, advanced practice registered nurses, and physician assistants, including (1) the bill's amendments to the offer of judgment law, (2) other provisions of the bill, and (3) any reduction in risk from using electronic patient health record systems.

CONTINGENCY FEES (§ 15)

Waiving Contingency Fee Limits

The law establishes a sliding scale of contingency fees attorneys may charge clients based on the amount of the settlement or judgment. It allows attorneys to collect (1) one-third of the first $300,000, (2) 25% of the next $300,000, (3) 20% of the next $300,000, (4) 15% of the next $300,000, and (5) 10% of amounts exceeding $1,200,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted this law to allow clients to waive its protections and agree to pay a higher contingency fee.

The bill invalidates a contingency fee arrangement for a medical malpractice case greater than the sliding scale's percentage limitations unless the court, after hearing the claimant attorney's application, grants a different arrangement. The bill prohibits the court from approving a contingency fee greater than one-third of the damages

awarded.

The bill requires the claimant's attorney to attach to the application a copy of the fee arrangement and the proposed unsigned writ, summons, and malpractice complaint. The fee arrangement must provide that (1) the attorney will advance all costs connected to investigating, prosecuting, or settling the case and (2) the claimant will not be liable for reimbursing any such costs if there is no recovery.

The bill requires that at the hearing the court address the claimant personally to determine if he understands his rights and has knowingly and voluntarily waived them.

The bill requires the court to grant the application if it finds that (1) the case is sufficiently complex, unique, or different from other medical malpractice cases as to warrant a deviation from the percentage limitations and (2) the claimant knowingly and voluntarily waived his rights to the statutory fee schedule. At the hearing, the claimant's attorney has the burden of showing that the deviation is warranted.

If the court denies the application, it must advise the claimant of his right to seek representation by another attorney willing to abide by the percentage limitations. The court's decision to grant or deny the application may not be appealed. Filing an application tolls the applicable statute of limitations until 90 days after the court's decision on it. The bill permits only one application to be filed regarding the claimant and his case.

The bill requires the chief court administrator to assign a judge or judges with experience in personal injury cases to hear and determine these applications. A hearing transcript must be prepared. It must be sealed and is available for the court's use only.

The bill prohibits an attorney from requiring a claimant to pay interest on the amount of any disbursements and costs the attorney makes in connection with investigating, prosecuting, or settling the malpractice claim.

Calculating Contingency Fee

For medical malpractice contingency fee arrangements approved by the court, the bill requires that the percentages that go to the client and

to the attorney be calculated after deducting any disbursements or costs the attorney incurred, other than ordinary office overhead and expenses.

MEDICAL MALPRACTICE DATA BASE—CLOSED CLAIM REPORTS (§ 16)

Closed Claim Reports

Prior law authorized the insurance commissioner to require all medical malpractice insurers in Connecticut to submit whatever information she deemed necessary to establish a medical malpractice database. The database could include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The bill instead requires, beginning January 1, 2006, each insurer to provide to the commissioner with a closed claim report, on whatever form she requires. A "closed claim" is one that has been settled, or otherwise disposed of, where the insurer has paid all claims regarding physicians, hospitals, advanced practice registered nurses, and physician assistants. The duty to report also applies to a captive insurers and a self-insured person or entity.

The bill requires the insurer to submit the report within 10 days after the end of the calendar quarter in which a claim is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The report must include the (1) insurer's name; (2) policy limits and whether it was an occurrence policy or was issued on a claims-made basis; (3) insured's name, address, license number, and specialty coverage; and (4) insured's policy number and unique claim number. (An "occurrence policy" provides protection for malpractice that occurred during the time the policy was in effect's a "claims-made" policy provides protection for claims made during the period the policy is in effect.)

Details About the Injury or Loss

The report must specify the (1) date of the injury or loss that was the basis of the claim; (2) date the injury or loss was reported to the insurer; (3) name of the institution or location where the injury or loss occurred; (4) type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity scale developed by the National Association of Insurance Commissioners; and (5) name, age, and gender of any injured person covered by the claim.

Any individually identifiable information (as defined by federal regulation) is confidential. The bill specifies that reporting this information is required by law. It requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information.

Details About the Claims Process

The bill specifies that details about the claims process include (1) whether a lawsuit was filed, and if so, in which court; (2) its outcome; (3) the number of other defendants, if any; (4) the stage in the process when the claim was closed; (5) the trial dates; (6) the date of any judgment or settlement; (7) whether an appeal was filed, and if so, the date filed; (8) the resolution of the appeal and the date it was decided; (9) the date the claim was closed; and (10) the initial and final initial indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The report must include:

1. the total amount of the initial judgment rendered by a jury or awarded by the court;

2. the total amount of the settlement if no judgment was rendered or awarded or the claim was settled after judgment was rendered or awarded;

3. the amount of economic and noneconomic damages, or the insurer's estimate of these amounts in the event of a settlement;

4. the amount of any interest awarded due to failure to accept an offer of judgment;

5. the amount of any remittitur (reduction) or additur (addition) and the amount of final judgment after such reductions or additions;

6. the amount the insurer paid;

7. the amount the defendant paid due to a deductible or a judgment or settlement in excess of policy limits;

8. the amount paid by other insurers or other defendants;

9. whether a structured settlement was used;

10. the expense assigned to and recorded with the claim, including defense and investigation costs but not including the actual claim payment; and

11. any other information the commissioner determines necessary to regulate the medical malpractice insurance industry, ensure its solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish a closed claim reports electronic database.

Annual Data Summary

The bill requires the insurance commissioner to aggregate the data included in individual closed claim reports into a summary and annually report the summary data. The report must analyze the closed claim information, including (1) a minimum of five years of comparative data, when available; (2) trends in frequency and severity of claims; (3) itemization of damages; (4) timeliness of the claims process; and (5) any other descriptive or analytical information that would help interpret the trends in closed claims.

The annual report must include a summary of rate filings for medical malpractice insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned

premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

The bill requires that, beginning March 15, 2007, and annually thereafter, the commissioner must annually submit the report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The bill requires the commissioner to provide the DPH commissioner with electronic access to all the closed case information she receives. It also requires the DPH commissioner to keep such information as confidential as the law requires the insurance commissioner to do.

DPH PATIENT SAFETY PROGRAMS (§ 17)

The bill requires the DPH commissioner to develop and implement a process to ensure a continuing and coordinated focus on patient safety programs in DPH. The process must encompass activities DPH undertakes to (1) coordinate state patient safety initiatives; (2) facilitate ongoing collaborations between the public and private sectors; (3) promote patient safety through educating health care providers and patients; (4) assure coordination in collecting, analyzing, and responding to adverse events reports; (5) coordinate state and federal patient safety programs; (6) participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors; and (7) promote the recommendations of the State Quality of Care Advisory Committee.

The bill requires that, beginning January 1, 2006, the commissioner annually report to the governor and the Public Health Committee chairmen on the process developed, its operation and impact, DPH's patient safety activities, and recommendations for future action.

MANDATORY REVIEW OF NONECOMOMIC DAMAGES OVER $1 MILLION (§ 18)

The bill requires the court, in any medical malpractice case in which the jury awards more than $1 million in noneconomic damages, to review the evidence to determine if the amount is excessive as a matter of law. It requires the court to consider whether it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake, or corruption. If the court concludes the award was excessive, it must order the plaintiff to remit the excessive amount. If the plaintiff refuses to do so, the court must set aside the verdict and order a new trial.

CAPTIVE INSURERS (§§ 19 AND 20)

A "captive insurer" is an insurance company owned by another organization and whose primary purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations, group members, and their affiliates.

The bill requires each captive insurer that offers, renews, or continues insurance in Connecticut to provide the following information to the insurance commissioner in the same manner required for risk retention groups:

1. a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;

2. a copy of each examination of the captive as certified by the commissioner or public official conducting the examination; and

3. at the commissioner's request, a copy of any audit performed with respect to the captive.

If a captive insurer does not maintain this information in this form, the bill permits it to submit the information to the commissioner on whatever form she prescribes.

The bill requires the commissioner to act as agent for service of process for risk retention groups domiciled outside the United States and for captive insurers. By law, the commissioner acts as agent for risk retention groups domiciled in another state that offer insurance in Connecticut.

PHYSCIAN PROFILE (§§ 21 AND 22)

The law requires DPH, after consulting with the Connecticut Medical Examining Board and the Connecticut State Medical Society, to collect the information on each licensed physician's training, practice, hospital privileges, malpractice, disciplinary, and criminal history.

The bill requires that the physician profile include the following additional information:

1. any disciplinary action taken against him by any licensing or disciplinary body outside of Connecticut;

2. whether he is providing direct patient care; and

3. the name of his liability insurance carrier and insurance policy number.

Under current law the physician must notify DPH of any change in practice speciality, location, language spoken in his primary office, board certification, hospital and nursing home privileges, and felony convictions. The bill requires the physician also to report changes to any of the other required information including:

1. disciplinary actions taken by the DPH or the state board;

2. hospital disciplinary actions resulting in the termination or revocation of his hospital privileges or the resignation from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital related to medical incompetence; and

3. all medical malpractice judgments and settlements.

ELIMINATION OF MALPRACTICE SCREENING PANEL (§ 23)

The bill eliminates the voluntary Medical Malpractice-Screening Panel.

Under current law, the parties must consent to use the panel. With their mutual agreement, the insurance commissioner or her designee selects panel members from lists of names submitted by the Connecticut State Medical Society and the Connecticut Bar Association. The panel is composed of two doctors and one attorney with trial experience in personal injury cases who acted as chairman. One of the doctors must practice in the same specialty as the defendant. Panel members can not be from communities in which the defendant doctor or the parties' attorneys practice. Panel members are not compensated. The panel holds confidential hearings when and where it decides and makes transcripts available at cost to either party.

The panel's conclusion as to liability is outlined in a finding signed by the members and recorded by the insurance commissioner. The panel does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The court or jury determines the weight assigned to such admissible findings. No member can be compelled to testify.

BACKGROUND

"Similar Health Care Provider"

By law, if the defendant health care provider is not certified by the appropriate American board as a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who is (1) licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who is (1) trained and experienced in the same specialty and (2) certified by the appropriate American board in the same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition that is not within his specialty, a

similar health care provider is a specialist trained in the treatment or diagnosis of that condition.

Sanctions if Certificate Not Filed in Good Faith

By law, the court must impose an appropriate sanction on the person who signed the certificate if it determines, after discovery is completed, that the certificate was not made in good faith and that no valid issue was presented against a health care provider who fully cooperated in providing informal discovery. It may also sanction the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court also may submit the matter to the appropriate authority for disciplinary review of a claimant's attorney who submitted the certificate.

Attorney Fees

Table 1 shows how the law's formula works for each of four hypothetical awards. It shows the actual amount of fees the statute allows the attorney to collect, the resulting percentage of the total award the attorney's fees constitute, and the amount and percentage the client would receive.

Table 1: Attorney's Fees for Various Damage Awards

Damage Award or Settlement	*Contingency Fee the Law Allows*	*Percentage of Total Award to Attorney*	*Amount Client Receives*	*Percentage of Total Award to Client*
$100,000	$33,333	33.3%	$66,667	66.7%
$500,000	$150,000	30%	$350,000	70%
$1,000,000	$250,000	25%	$750,000	75%
$5,000,000	$660,000	13. 2%	$4,540,000	86. 8%
$10,000,000	$1,160,000	11. 6%	$8,840,000	88. 4%

Waiver of Fee Schedule

Current statute does not explicitly indicate whether a client can waive the statutory contingency fee limits. One Superior Court case held that tort victims could waive their rights to the protections afforded by the contingency fee law. It also decided the plaintiff's waiver was valid, and the fee arrangement the plaintiff entered into with her attorney

was reasonable (*In re Estate of Salerno,* 42 Conn. Supp. 526 (1993)).

The court resolved the case on nonconstitutional grounds, noting that rights granted by statute could be waived unless the statute is meant to protect the general rights of the public rather than private rights. It cited instances where statutes relating to litigation have been construed as conferring a private right that can be waived (e. g., statute of limitations for tort actions, right to trial by jury, defense of statute of fraud).

It concluded that the fee cap statute clearly confers a private right and does not protect the general rights of the public. It also cited the legislative history in which proponents of the law indicated that the fee limits could be waived.

Complaints Against Doctors Filed With DPH

A person may file a petition against a doctor for the same reasons the Medical Examining Board may discipline a doctor. These include:

1. physical illness or loss of motor skill, including deterioration through the aging process;

2. emotional disorder or mental illness;

3. abuse or excessive use of drugs or alcohol;

4. illegal, incompetent, or negligent conduct in the practice of medicine;

5. possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;

6. misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice medicine;

7. failure to maintain required professional liability insurance;

8. performing any activity for which accreditation is required by law without the appropriate accreditation; and

9. violation of any law regulating medicine and surgery or any regulation adopted under such laws.

Individually Identifiable Health Information

Individually identifiable health information is defined by federal regulation (45 CFR 160.103) as including demographic information, collected from an individual that:

1. is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. relates to an individual's past, present, or future physical or mental health or condition, providing health care to an individual, or paying for the provision of health care to an individual, and that (a) identifies the individual or (b) may lead to a reasonable belief that it could be used to identify the individual.

Licensed Health Care Providers and Institutions

The mediation and offer of judgment provisions apply to medical malpractice lawsuits filed against the following licensed health care providers:

1. doctors and surgeons,
2. chiropractors,
3. natureopaths,
4. podiatrists,
5. athletic trainers,
6. physical and occupational therapists,
7. substance abuse counselors,
8. radiographers and radiologic technologists,
9. midwives,
10. nurses and nurses aides,
11. dentists and dental hygienists,
12. optometrists and opticians,
13. respiratory care practitioners,
14. pharmacists,
15. psychologists,
16. marital therapists and professional counselors,
17. clinical social workers,

18. veterinarians,
19. massage therapists,
20. electrologists,
21. hearing instrument specialists and audiologists,
22. ambulance drivers, and
23. emergency medical technicians and communications personnel.

The provisions also apply to the following health care institutions: hospitals; outpatient surgical facilities; residential care homes; health care facilities for the handicapped; nursing homes; rest homes; home health and homemaker-home health aide agencies; mental health and substance abuse treatment facilities; college infirmaries; diagnostic and treatment facilities, including those operated and maintained by a state agency, except facilities for the care or treatment of mentally ill or substance abusing people; and intermediate care facilities for the mentally retarded.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 15 Nay 0